Student Registration Packet

Whitesboro Central School District

65 Oriskany Blvd. Suite 1
Whitesboro, NY 13492
(315) 266-3300

Our Mission

"To inspire, cultivate and empower all learners to maximize their potential"

Our Vision

"Together with our community, the Whitesboro Central School District provides a dynamic, comprehensive program committed to relevant, engaging, individualized experiences, while fostering a culture of personal and professional growth in a safe, diverse, positive learning environment."

Whitesboro Central School District

65 Oriskany Blvd. Suite 1 • Whitesboro, NY 13492 • www.wboro.org

High School: 315.266.3200 | **Middle School:** 315.266.3100 | **Parkway School:** 315.266.3176
Deerfield Elementary: 315.266.3410 | **Hart's Hill Elementary:** 315.266.3430
Marcy Elementary: 315.266.3420 **Westmoreland Road Elementary:** 315.266.3440

Summary of Forms and Procedures - Registration Checklist

Welcome to the Whitesboro Central School District! In order to complete the registration process, the District needs specific information and records. This Student Registration Packet must be completed and submitted to the main office of your child's school. If you need assistance determining your home school, please contact the District office at (315) 266-3302. The packet is available electronically on the District website at http://www.wboro.org/registration or from the main office of each school. If you have questions while completing this packet, or require forms in another language, please contact your child's school.

Where to File:		
Deerfield Elementary 115 Schoolhouse Rd. Deerfield, NY 13502 (315) 266-3410 **Grades K-5**		Hart's Hill Elementary 8615 Clark Mills Rd. Whitesboro, NY 13492 (315) 266-3430 **Grades K-5**
Marcy Elementary 9479 Maynard Dr. Marcy, NY 13403 (315) 266-3420 **Grades K-5**		Westmoreland Road Elementary 8596 Westmoreland Rd. Whitesboro, NY 13492 (315) 266-3440 **Grades K-5**
Parkway School 65 Oriskany Blvd. Whitesboro, NY 13492 (315) 266-3176 **Grades 6-8**	Middle School Campus 75 Oriskany Blvd. Whitesboro, NY 13492 (315) 266-3100 **Grades 6-8**	High School 6000 Route 291 Marcy, NY 13403 (315) 266-3200 **Grades 9-12**
	Whitesboro CSD District Office 65 Oriskany Blvd., Suite 1 Whitesboro, NY 13492 (315) 266-3300	

REGISTRATION CHECKLIST

Required Forms

- ☐ Student Registration Form
- ☐ Enrollment Form – Residency Questionnaire
- ☐ Home Language Questionnaire (HLQ)
- ☐ Health Exam Form
- ☐ Student Health History
- ☐ Dental Health Certificate
- ☐ Authorization for Administration of Medication (if applicable)
- ☐ Child Care/Alternate Transportation Request
- ☐ Application for Free and Reduced Price School Meals/Milk (if applicable)
- ☐ Parent Affidavit (if applicable)
- ☐ Migrant Education Program - Parent Survey

Additional Required Documentation

☐ Proof of Residency
Parent(s)/Guardian(s) must provide **three (3)** proofs of residency in the Whitesboro School District.

Examples of documentation include **current** versions of the following:

- Deed or mortgage statement
- Utility bill (National Grid, Mohawk Valley Water Authority, etc.)
- Cell phone/home phone bill
- Homeowner's insurance bill
- Change of address paperwork from the Post Office
- Driver's license/permit/identification card
- Paperwork associated with the purchase of a home
- Signed copy of a residential lease
- Pay stub
- Income tax form
- Voter registration document

☐ Proof of Age (Date of Birth)
One (1) of the following documents must be provided:

- An original birth certificate
- Original passport
- Record of baptism

☐ Certificate of Immunization from Doctor or County Health Department

☐ Most Recent Report Card/Current Grades
Parent(s)/Guardian(s) must provide copies of most current grades and/or report card(s).

☐ Confidential Records (If Applicable)
Examples include Individualized Education Programs (IEPs), 504 Plans, Psychological Testing, etc.

☐ Parental/Custodial Affidavits (If Applicable)
If the student is residing with someone other than Parent(s)/Guardian(s), you must complete a Parent/Affidavit Form. Forms must be completed and notarized.

☐ Custody Agreements, Separation Agreements, Divorce Decrees, etc. (If Applicable)

Whitesboro Central School District

65 Oriskany Blvd. Suite 1 • Whitesboro, NY 13492 • www.wboro.org

High School: 315.266.3200 | **Middle School:** 315.266.3100 | **Parkway School:** 315.266.3176
Deerfield Elementary: 315.266.3410 | **Hart's Hill Elementary:** 315.266.3430
Marcy Elementary: 315.266.3420 **Westmoreland Road Elementary:** 315.266.3440

Date: / / (MM DD YYYY)

Student Registration Form

Student Information:

Last Name:	First Name:	Middle Name:
Date of Birth: / / (MM DD YYYY)	Place of Birth (City/Town):	State (Country, if not U.S.):
Gender: ○ Male ○ Female	Is this student a foster child? ○ Yes ○ No	Current Grade: Choose One

Are either or both of the child's parents/guardians active members of the U.S. Armed Forces? ○ Yes ○ No

Student's Address:

Street Address:		Apt. #:	Home Phone #: ( ) —
City/Town:	State: **NY**	Zip Code:	Cell Phone #: ( ) —

Is this address a temporary living arrangement? ○ Yes ○ No

Education Information:

Student is currently enrolled in *(please check all that apply):*

☐ Reading ☐ Math ☐ Special Education ☐ Speech ☐ English as a New Language (ENL) ☐ None ☐ Other

Does the student have an Individualized Education Program (IEP)? ○ Yes ○ No

Does the student have a 504 Plan? ○ Yes ○ No

Has the student ever attended public school in New York State? ○ Yes ○ No

If yes, please specify most recent: District: _____ School: _____

Grade(s): _____ Year(s): _____

Name, Address and Phone # of Most Recent School Attended:

Name of School:		Grade(s):	Dates Enrolled: From: / / (MM DD YYYY)
Street Address:		Phone #: ( ) —	
City/Town:	State: Choose One	Zip Code:	To: / / (MM DD YYYY)

Ethnicity:

Hispanic/Latino: ○ Yes ○ No

Race *(Choose all that apply regardless of Ethnicity)*:

☐ American Indian or Native American
☐ Asian
☐ Black or African American
☐ White
☐ Native Hawaiian or Other Pacific Islander

PLEASE FILL OUT STUDENT NAME FIELDS IN THE EVENT THAT THE PAGES OF THIS FORM BECOME DETACHED.

STUDENT LAST NAME:	STUDENT FIRST NAME:

Parent/Guardian Information:

Parent/Guardian #1:

Relation to Student: ○ Mother ○ Father ○ Step-parent ○ Foster Parent ○ Guardian ○ Other _____

Last Name:	First Name:	M.I.:
Street Address:		Apt. #:
City/Town:	State: Choose One	Zip Code:
Home Phone #: ( ) –	Cell Phone #: ( ) –	Work Phone #: ( ) –
Email:		

Parent/Guardian #2:

Relation to Student: ○ Mother ○ Father ○ Step-parent ○ Foster Parent ○ Guardian ○ Other _____

Last Name:	First Name:	M.I.:
Street Address:		Apt. #:
City/Town:	State: Choose One	Zip Code:
Home Phone #: ( ) –	Cell Phone #: ( ) –	Work Phone #: ( ) –
Email:		

Primary Emergency Contact Information *(other than parent/guardian):*

Last Name:	First Name:	Relationship to Student:
Home Phone #: ( ) –	Cell Phone #: ( ) –	Work Phone #: ( ) –

Secondary Emergency Contact Information *(other than parent/guardian):*

Last Name:	First Name:	Relationship to Student:
Home Phone #: ( ) –	Cell Phone #: ( ) –	Work Phone #: ( ) –

Physician Information:

Name of Physician:		
Street Address:		Phone #: ( ) –
City/Town:	State: Choose One	Zip Code:

PLEASE FILL OUT STUDENT NAME FIELDS IN THE EVENT THAT THE PAGES OF THIS FORM BECOME DETACHED.

STUDENT LAST NAME:	STUDENT FIRST NAME:

Children in Household (*Please list other children in your household birth through grade 12):*

	Last Name:	First Name:	Middle Name:	Date of Birth:	Gender:
1				/ / MM DD YYYY	○ Male ○ Female
2				/ / MM DD YYYY	○ Male ○ Female
3				/ / MM DD YYYY	○ Male ○ Female
4				/ / MM DD YYYY	○ Male ○ Female
5				/ / MM DD YYYY	○ Male ○ Female
6				/ / MM DD YYYY	○ Male ○ Female
7				/ / MM DD YYYY	○ Male ○ Female
8				/ / MM DD YYYY	○ Male ○ Female
9				/ / MM DD YYYY	○ Male ○ Female
10				/ / MM DD YYYY	○ Male ○ Female
11				/ / MM DD YYYY	○ Male ○ Female
12				/ / MM DD YYYY	○ Male ○ Female

PLEASE FILL OUT STUDENT NAME FIELDS IN THE EVENT THAT THE PAGES OF THIS FORM BECOME DETACHED.

STUDENT LAST NAME:	STUDENT FIRST NAME:

Certification:

To the Parent/Guardian: The information asked on the previous pages is needed as a permanent school record of your child and will be used by school personnel. This is to certify the information provided is correct. In the event a parent/guardian cannot be reached, I give my permission for emergency medical treatment to be administered to my child, and for officials of the school to contact the physician named on this form. I will not hold the school district financially responsible for the emergency care and/or transportation of my child.

_____ **Date:** ____/____/____
MM DD YYYY

Parent/Guardian Name *(please print):*

_____

Parent/Guardian Signature

Section 4402 of the Education Law of the State of New York requires the District to notify the parents/guardians of all incoming students of their rights regarding referral and evaluation for possible special education services. The state has made available "A Parent's Guide to Special Education" at: http://www.p12.nysed.gov/specialed/publications/policy/parentsguide.pdf

The guide provides a summary of the special education process and your child's rights under state and federal law. If you have any questions or would like a paper copy of the above guide, please contact the Office of Special Programs at (315) 266-3309.

Whitesboro Central School District

65 Oriskany Blvd. Suite 1 • Whitesboro, NY 13492 • www.wboro.org

High School: 315.266.3200 | **Middle School:** 315.266.3100 | **Parkway School:** 315.266.3176
Deerfield Elementary: 315.266.3410 | **Hart's Hill Elementary:** 315.266.3430
Marcy Elementary: 315.266.3420 **Westmoreland Road Elementary:** 315.266.3440

Date: / / MM DD YYYY

Residency Questionnaire

Student Information:

Last Name:	First Name:	Middle Name:
Gender: ○ Male ○ Female	Grade: Choose One	Date of Birth: / / MM DD YYYY

Parent/Guardian Information:

Last Name:	First Name:	M.I.:
Street Address:		Apt #:
City/Town:	State: Choose One	Zip Code:
Home Phone #: ( ) –	Cell Phone #: ( ) –	Work Phone #: ( ) –

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Student Residency:

Where is the student currently living? *(Please check **one** box.)*

- ○ In a shelter
- ○ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ○ In a hotel/motel
- ○ In a car, park, bus, train, or campsite
- ○ In permanent housing
- ○ Other temporary living situation (Please describe):

_____

Name of Parent, Guardian, or Student (*please print*)**:**

_____ **Date:** _____/_____/_____

Signature of Parent, Guardian, or Student *(for unaccompanied homeless youth)*: MM DD YYYY

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:

❑ Male
■ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other _____ *specify*	
2. What was the first language your child learned?	❑ English	❑ Other _____ *specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother _____ *specify*	❑ Father _____ *specify*	❑ Guardian(s) _____ *specify*
4. What language(s) does your child understand?	❑ English	❑ Other _____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other _____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other _____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other _____ *specify*	❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	**STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:**
District Name (Number) & School *Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes* ☐ ***No*** ☐ ***Not sure*** ☐ ***If yes,** please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

10b. *If referred for an evaluation, has your child ever *received* any special education services in the past?
❑ No ❑ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ❑ No ❑ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ Mother ❑ Father ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

****DATE OF INDIVIDUAL INTERVIEW:** _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:** _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors:Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

Percentile (Weight Status Category): ☐ < 5th ☐ 5th- 49th ☐ 50th- 84th ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

FOR PARTICIPATION IN PHYSICAL EDUCATION*/SPORTS*/PLAYGROUND/WORK

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

Whitesboro Central School District

65 Oriskany Blvd. Suite 1 • Whitesboro, NY 13492 • www.wboro.org

High School: 315.266.3200 | **Middle School:** 315.266.3100 | **Parkway School:** 315.266.3176
Deerfield Elementary: 315.266.3410 | **Hart's Hill Elementary:** 315.266.3430
Marcy Elementary: 315.266.3420 **Westmoreland Road Elementary:** 315.266.3440

Date: / / MM DD YYYY

Student Health History

Student Information:

Last Name:	First Name:		M.I.:
Date of Birth: / / MM DD YYYY	Place of Birth:	Gender: ○ Male ○ Female	Home Phone #: ( ) —
Street Address:	City/Town:	State: **NY**	Zip Code:

Parent/Guardian Information:

Parent/Guardian #1:

Last Name:	First Name:		M.I.:
Street Address:	City/Town:	State: Choose One	Zip Code:
Home Phone #: ( ) —	Cell Phone #: ( ) —	Work Phone #: ( ) —	
Employer:			

Parent/Guardian #2:

Last Name:	First Name:		M.I.:
Street Address:	City/Town:	State: Choose One	Zip Code:
Home Phone #: ( ) —	Cell Phone #: ( ) —	Work Phone #: ( ) —	
Employer:			

Physician Information:

Family Physician:	Physician's Phone #: ( ) —

Emergency Contact Information *(if parent not available)*:

Last Name:	First Name:	Relation to Student:
Home Phone #: ( ) —	Cell Phone #: ( ) —	Work Phone #: ( ) —

Education Information:

School Previously Attended (name, city, state):	Building and Grade Entering:

Health History Information - If child has had any of the following, *please specify date:*

Chicken Pox:	/ MM YYYY	Diabetes:	/ MM YYYY	Operations:
German Measles:	/ MM YYYY	Ear Problems:	/ MM YYYY	
Mumps:	/ MM YYYY	Epilepsy:	/ MM YYYY	Serious Injuries:
Measles:	/ MM YYYY	Heart Problems:	/ MM YYYY	
Pneumonia:	/ MM YYYY	Asthma:	/ MM YYYY	
Rheumatic Fever:	/ MM YYYY	Allergies:	/ MM YYYY	Other:
Scarlet Fever:	/ MM YYYY	Contact with Tuberculosis:	/ MM YYYY	

Is the student currently under care for any special health problems? If yes, please explain:

PLEASE NOTE: In accordance with New York State Education Law, a Certificate of Immunization from a doctor or County Health Department **MUST BE PRESENTED** when registering a student for school.

_____

Parent/Guardian Name (*please print*)**:**

_____ **Date:** _____ / _____ / _____

Parent/Guardian Signature: MM DD YYYY

Whitesboro Central School District

65 Oriskany Blvd. Suite 1 • Whitesboro, NY 13492 • www.wboro.org

High School: 315.266.3200 | **Middle School:** 315.266.3100 | **Parkway School:** 315.266.3176
Deerfield Elementary: 315.266.3410 | **Hart's Hill Elementary:** 315.266.3430
Marcy Elementary: 315.266.3420 **Westmoreland Road Elementary:** 315.266.3440

Date: ___/___/___ (MM DD YYYY)

Authorization for Administration of Medication (If Applicable)

STUDENT INFORMATION (TO BE COMPLETED BY A PARENT/GUARDIAN):

Last Name:	First Name:	Middle Name:
Date of Birth: ___/___/___ (MM DD YYYY)	Grade: Choose One	Teacher *(if applicable)*:

I understand that the school nurse, or other designated person will administer the medication and/or assist my child with medication during school activities such as field trips, athletic events etc. during the ____–____ (YYYY YYYY) school year. I will provide the medication in the original pharmacy or over-the-counter container. I understand that this plan will be shared with school staff caring for my child. The medication(s) is/are to be administered during the current school year or until terminated by written notice.

_____ **Date:** ___/___/___ (MM DD YYYY)
Parent/Guardian Name *(please print)*:

_____ **Date:** ___/___/___ (MM DD YYYY)
Parent/Guardian Signature:

Home Phone #: (___) ___–____ **Cell Phone #:** (___) ___–____ **Work Phone #:** (___) ___–____

MEDICATION INFORMATION (TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER):

Diagnosis:		
Medication:		
Dose:	Route:	Frequency/Time(s):
Diagnosis:		
Medication:		
Dose:	Route:	Frequency/Time(s):

_____ **Date:** ___/___/___ (MM DD YYYY)
Prescriber's Name and Title *(please print):*

_____ **Phone #:** (___) ___–____
Prescriber's Signature:

HEALTH CARE PROVIDER PERMISSION FOR INDEPENDENT USE AND CARRY (IF REQUIRED):

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity.

_____ **Date:** ___/___/___ (MM DD YYYY)
Prescriber's Signature:

PARENT/GUARDIAN PERMISSION FOR INDEPENDENT USE AND CARRY (IF REQUIRED):

I agree that my child can use their medication(s) effectively and may carry and use this medication independently at any school/school sponsored activity. As the parent/guardian, I accept the responsibility regarding monitoring my child on an ongoing basis to ensure that the child is carrying and taking the medication as ordered by their health care provider.

_____ **Date:** ___/___/___ (MM DD YYYY)
Parent/Guardian Signature:

Whitesboro Central School District

65 Oriskany Blvd. Suite 1 • Whitesboro, NY 13492 • www.wboro.org

High School: 315.266.3200 | **Middle School:** 315.266.3100 | **Parkway School:** 315.266.3176
Deerfield Elementary: 315.266.3410 | **Hart's Hill Elementary:** 315.266.3430
Marcy Elementary: 315.266.3420 **Westmoreland Road Elementary:** 315.266.3440

Date: ___/___/___ (MM DD YYYY)

Dental Health Certificate - Optional

Parent/Guardian: New York State Law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 1, 3, 5, 7, 9, 11. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section I and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section II.

Return the completed form to your child's school as soon as possible.

SECTION I TO BE COMPLETED BY PARENT OR GUARDIAN:

Last Name:	First Name:	Middle Name:
Date of Birth: ___/___/___ (MM DD YYYY)	Gender: ○ Male ○ Female	Will this be your child's first oral health assessment? ○ Yes ○ No
School Name:		Grade: Choose One

Have you noticed any oral problems that interfere with your child's ability to chew, speak or focus on school activities? ○ Yes ○ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays, if necessary, to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

_____
Parent/Guardian Name *(please print):*

_____ **Date:** ___/___/___ (MM DD YYYY)
Parent/Guardian Signature:

SECTION II ITEMS 1-3 TO BE COMPLETED BY THE DENTIST/DENTAL HYGIENIST:

1. The dental health condition of _____ (Name of child) on ___/___/___ (MM DD YYYY) (date of assessment)

The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ **Yes**, The student listed above is in fit condition of dental health to permit his/her attendance at public schools.

☐ **No**, The student listed above is not in fit condition of dental health to permit his/her attendance at public schools.

NOTE: *"Not in fit condition of dental health" means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of "not in fit condition of dental health to permit attendance at public schools" does not preclude the student from attending school.*

Dentist's Office Name:	_____ **Dentist's/Dental Hygienist's Name** *(please print)*:
Dentist's Office Address:	_____ **Dentist's/Dental Hygienist's Signature:**

PLEASE FILL OUT STUDENT NAME FIELDS IN THE EVENT THAT THE PAGES OF THIS FORM BECOME DETACHED.

STUDENT LAST NAME:	STUDENT FIRST NAME:

SECTION II CONTINUED - ITEMS 1-3 TO BE COMPLETED BY THE DENTIST/DENTAL HYGIENIST:

Optional Information - Parent/Guardian, if you agree to release this information to your child's school, please initial in the box to the right.

INITIAL HERE

2. Oral Health Status:

○ Yes ○ No **Caries Experience/Restoration History -** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

○ Yes ○ No **Untreated Caries** - Does this child have an open cavity? [At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

○ Yes ○ No **Dental Sealants Present**

Other problems (Specify):

Optional Information - Parent/Guardian, if you agree to release this information to your child's school, please initial in the box to the right.

INITIAL HERE

3. Treatment Needs:

○ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

○ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

○ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

Whitesboro Central School District

65 Oriskany Blvd. Suite 1 • Whitesboro, NY 13492 • www.wboro.org

High School: 315.266.3200 | **Middle School:** 315.266.3100 | **Parkway School:** 315.266.3176
Deerfield Elementary: 315.266.3410 | **Hart's Hill Elementary:** 315.266.3430
Marcy Elementary: 315.266.3420 **Westmoreland Road Elementary:** 315.266.3440

Date: / / (MM DD YYYY)

Child Care/Alternate Transportation Request

If your children will be picked up and/or dropped off, ***regularly***, at a place **other than his/her home for the school year**, please fill out this form.

MY CHILD(REN):		
Name:	Grade: Choose One	Teacher (if known):
Name:	Grade: Choose one	Teacher (if known):

PICKUP INFORMATION:

☐ Will be **picked up at:**

Name of sitter: _____

Address of sitter: _____

Sitter's telephone: _____

On following days: _____

☐ Will be **dropped off at:**

Name of sitter: _____

Address of sitter: _____

Sitter's telephone: _____

On following days: _____

☐ My child attends **St. Paul's** ☐ Before School Care ☐ After School Care

Days: _____

☐ My child attends **Treehouse** ☐ Before School Care ☐ After School Care

Days: _____

Date: _____ / / _____ (MM DD YYYY)

_____
Parent/Guardian Signature

_____
Daytime Telephone

_____
Address of Parent/Guardian

Whitesboro Central School District

65 Oriskany Blvd. Suite 1 • Whitesboro, NY 13492 • www.wboro.org

High School: 315.266.3200 | **Middle School:** 315.266.3100 | **Parkway School:** 315.266.3176
Deerfield Elementary: 315.266.3410 | **Hart's Hill Elementary:** 315.266.3430
Marcy Elementary: 315.266.3420 **Westmoreland Road Elementary:** 315.266.3440

Date: ___/___/___ (MM DD YYYY)

Parent Affidavit Form

If the student is residing with someone other than Parent(s)/Guardian(s), you must complete this form.
THIS FORM MUST BE NOTARIZED.

State: **NY**	County:	Social Security #: - -

_____ (First Name of Parent) _____ (Last Name of Parent), **being duly sworn, deposes and says:**

1. I am the _____ (Relationship to Student) of _____ (Name of Student).

2. I reside at _____ (Address).

3. [Check one that applies] ☐ I do ☐ I do not have legal custody of the Student.
(Attach court/custody papers if parents are separated/divorced.)

4. If the other parent has legal custody, identify that person by name, address and telephone number, and provide a notarized statement form that parent indicating consent to the current living arrangement.

First Name:	Last Name:	
Address:		Apt. #:
City/Town:	State: Choose One	Zip Code:
Home Phone #: ( ) -	Cell Phone #: ( ) -	Work Phone #: ( ) -

5. The Student is currently residing with _____ (First Name) _____ (Last Name) at the following address:

Address:		Apt. #:
City/Town:	State: Choose One	Zip Code:
Relationship to Student:		

6. The Student began living at the current residence on ___/___/___ (MM DD YYYY) and will continue to reside there until ___/___/___ (MM DD YYYY).

7. Why is the student living at the current location?

8. Will the Student reside in your home during weekends, holidays or any other times during his/her stay in the current location? ☐ Yes ☐ No

PLEASE FILL OUT STUDENT NAME FIELDS IN THE EVENT THAT THE PAGES OF THIS FORM BECOME DETACHED.

STUDENT LAST NAME:	STUDENT FIRST NAME:

9. Who will claim the Student as a dependent for Income Tax purposes? _____ (First Name) _____ (Last Name)

10. Who will claim the Student for Income Tax purposes? _____ (First Name) _____ (Last Name)

11. During the time the Student resides at the current location, who is responsible for:

A. Receiving and responding to academic and other reports concerning the Student?

_____ (First Name) _____ (Last Name)

B. Making decisions regarding the Student's Education?

_____ (First Name) _____ (Last Name)

C. Authorizing medical treatment for the Student?

_____ (First Name) _____ (Last Name)

D. Payment for medical treatment of the Student?

_____ (First Name) _____ (Last Name)

E. Relasing records for the Student?

_____ (First Name) _____ (Last Name)

F. Providing other necessary consents for the Student?

_____ (First Name) _____ (Last Name)

G. Expense of Student's room and board?

_____ (First Name) _____ (Last Name)

H. Expenses of clothing and other necessities?

_____ (First Name) _____ (Last Name)

Will you provide any other financial assistance to the Student? ☐ Yes ☐ No

If yes, what is the nature and amount of the assistance?

PLEASE FILL OUT STUDENT NAME FIELDS IN THE EVENT THAT THE PAGES OF THIS FORM BECOME DETACHED.

STUDENT LAST NAME:	STUDENT FIRST NAME:

12. Other information that would assist the School District with this matter:

I certify that all the information provided on this affidavit is true and accurate.

I understand that:

A. If I provide false information on this affidavit to the Whitesboro Central School District, I may be committing the crime of perjury in the third degree (a class A misdemeanor.);

B. If I provide false information on this affidavit to the Whitesboro Central School District with the intent to defraud the Whitesboro Central School District, I may be committing the crime of perjury in the second degree (a class E felony); and

C. I may be prosecuted on criminal charges for such false information.

_____

Parent/Guardian Name *(please print):*

_____

Parent/Guardian Signature

Sworn to me on this Choose One
(Day)

day of Choose One (Month) , 20 _____ (Year).

_____

Notary Public Signature

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- ☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- ☐ Work related to logging, harvesting, or initial processing of trees.
- ☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)

If you answered YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____

Telephone number: (_____)-_____-_____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____Grade_____

Student name: _____ Age _____Grade_____

To submit this referral please fax to 607-436-3606, or by mail to NYS Migrant Education Program-Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.